STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591

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F0000	This visit was for the Investigation of Complaint IN00117308 and Complaint IN00118808. Complaint IN00117308- Substantiated, Federal/State deficiencies are cited at F157 and F323. Complaint IN00118808- Substantiated, no deficiencies related to the allegations are cited. Survey dates: October 26, 29, 30, 2012 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Survey team: Anne Marie Crays, RN Census bed type: SNF: 19 SNF/NF: 107 Total: 126 Census payor type: Medicare: 30 Medicaid: 77 Other: 19 Total: 126	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective November16, 2012 to the complaint survey conducted on October 26 through October 30, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 31, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure a resident's physician was notified timely of a resident's fall in which the resident hit her head for 1 of 6 residents reviewed for	F0157	**F157** **It is the practice of this facility to assure that the physician and family are notified appropriately in accordance with the guidelines related to incidents.**	11/16/2012

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	physician notification of falls in a sample of 6. Resident A Findings include: 1. The clinical record of Resident A was reviewed on 10/26/12 at 1:50 P.M. Nurses notes included the following notations: 10/11/12 at 6:45 P.M.: "CNA calling me to Rs [resident] room, I find Rs lying on her abdomen on floor by BSC [bedside commode]...denies pain, hip FX [fracture] assessment neg [negative], purple bruise [with] lump noted to [left] forehead, slight abrasion to [right] knee....ice pack applied to head." 10/12/12 at 9:00 A.M.: "Res. [resident] now beginning to c/o [complain of] generalized LLE [left lower extremity] pain...Bump remains to Lt [left] forehead...Will have chg [charge] nurse to notify [physician] to obtain X-rays to R/O [rule out] any Fx's..." 10/12/12 at 9:05 A.M.: Call out to [physician] office...spoke about incident et [and] Res c/o pain LLE...." Over fourteen hours passed before the MD was notified of the resident's fall.		***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident A's physician is aware of the resident's condition. ***Other residents that have the potential to be affected have been identified by:*** All residents that have had a fall in the past 30 days have been reviewed to assure that physician/families have been notified appropriately ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses have been in-serviced related to the importance of physician/family notification with significant changes including the incident of falls. The in-service included the expectations related to notifying physicians after hours. As the interdisciplinary team is reviewing all incidents on each business day, they are reviewing all documentation to assure that the physician/family was notified appropriately. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review incidents to assure that the physician/family have been notified in accordance with the	

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	On 10/26/12 at 2:40 P.M., during interview with Unit Manager # 1, she indicated she had spoken to RN # 1, who was working the evening that Resident A had fallen. RN # 1 indicated she didn't think staff was to call the physician "after hours." Unit Manager # 1 indicated the resident had not complained of pain at the time of the fall, and RN # 1 had started neurological checks. Unit Manager # 1 indicated RN # 1 was a "new nurse to the facility." Unit Manager # 1 indicated she informed RN # 1 that physicians could be called after hours. 2. On 10/30/12 at 10:45 A.M., the Director of Nursing provided the current facility policy on "Required notifications, Significant change in condition," dated 2006. The policy included: "The facility notified the resident's physician...whenever there is an accident resulting in injury or that has the potential for requiring physician intervention...." This federal tag relates to Complaint IN00117308. 3.1-5(a)(1)		regulation. The tool will randomly review 5 residents (if applicable) with a fall/incident. Nursing Administration, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools ***The date the systemic changes will be completed:*** November 16, 2012	

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure supervision was provided to a cognitively impaired resident at risk for falls while sitting on the commode, resulting in a fall and left hip fracture, for 1 of 6 residents reviewed for falls, in a sample of 6. Resident A Findings include: 1. On 10/26/12 at 10:00 A.M., during the initial tour, the Director of Nursing [DON] indicated Resident A had fallen and obtained a fracture. The DON indicated the resident had periods of confusion. On 10/26/12 at 11:30 A.M., Resident A was observed lying in bed. Bruising was observed on the left forehead area. The clinical record of Resident A was reviewed on 10/26/12 at 1:50 P.M. Diagnoses included Acute CVA [left] side flaccid, and History of Alzheimer's disease.	F0323	**F323** **It is the practice of Willow Manor to assure that interventions are in place to assist with the prevention of falls** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #A has been reassessed related to fall risk and have been reviewed by the IDT to assure that appropriate interventions are in place to assist with the prevention of falls. The plans of care have been updated as well as the CNA assignment sheets as indicated. ***Other residents that have the potential to be affected have been identified by:*** All residents have been re-assessed related to fall risk. Based on the assessment, interventions have been implemented to assist with the prevention of falls. The plans of care and the CNA assignment sheets have been updated if indicated. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team is	11/16/2012

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	A Care Plan, dated 6/14/11 and updated 7/21/12, indicated: "Problem, Fall risk, Potential for Injury: Related to: Unsteady gait, Cognitive deficits, Weakness, Use of psychotropic medications, Impaired mobility, Balance problem, CVA with left sided weakness... As evidenced by: History of falls, Unable to ambulate, Unable to transfer without assistance...May be up with assist times two, gait belt, pivot transfer...." A Nursing Assessment, dated 8/15/12, indicated, "...Non ambulatory, [Left] side paralysis d/t [due to] CVA...Functional Status, 2 person assist...Paralysis...Communication/Mood/ Behavior, garbled speech, Alert to person...Bedrail Safety Assessment...Does resident have difficulty with balance or poor trunk control? [Yes]...Fall Risk Assessment...Disoriented x 3 at all times, Chair bound - requires assist with elimination, Not able to perform gait/balance test...Total score 10 ["A score of 10 or more represents high risk for falls"]." A Minimum Data Set [MDS] assessment, dated 8/19/12, indicated the resident scored a 5 out of 15 for mental status, with 15 indicating no memory impairment. The MDS assessment		reviewing all fall risk assessments to assure interventions are in place to assist with the prevention of falls. Based on the assessment, the plan of care is being updated to reflect appropriate interventions. In addition, the CNA assignment sheet is being updated to include all necessary interventions to assist with the prevention of falls. An in-service has been conducted for the nurses to assure that there is a thorough understanding of fall interventions being in place based on the plan of care. All nursing staff has been in-serviced related to providing services to residents in accordance with the plan of care. As part of the system change, the Interdisciplinary team will review all falls and assure that the care plan and CNA assignment sheets have been updated to reflect appropriate interventions based on the possible cause of the fall each business day. In addition, the nurses will notify the nursing manager following any fall to assure that all appropriate interventions/actions have been taken properly. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents that are considered “High Risk of Falls” or who have had an	

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	indicated the resident required extensive assistance of two+ staff for transfer and toilet use, and did not ambulate. A test for balance while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer indicated "Not steady, only able to stabilize with staff assistance." Nurse's Notes included the following notations: 10/11/12 at 6:45 P.M.: "CNA calling me to Rs [resident] room. I find Rs [resident] lying on her abdomen on floor by BSC [bedside commode]...denies pain, hip Fx [fracture] assessment neg [negative], purple bruise [with] lump noted to [left] forehead, slight abrasion to [right] knee...Neuro [checks] initiated, ROM [range of motion] same as before fall, LOC [level of consciousness] [no change]...ice pack applied to [left] forehead." 10/12/12 at 3:00 A.M.: In bed, awake, [no] c/o pain/discomfort." 10/12/12 at 9:00 A.M.: Res. [resident] now beginning to c/o generalized LLE [left lower extremity] pain. [Nothing] specific just states 'hurts.' Upon assmnt [sic] [no] internal/external rotation noted to the LLE...Bump remains to Lt [left]		actual fall to assure that proper preventive interventions are implemented. The tool will also assure that the plan of care as well as the CNA assignment sheets are updated appropriately. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** 11-16-12	

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	side of forehead...(Pts [patient's] LLE has hx [history] of being effected [secondary to] CVA). Pt usually rings her call light when needs [assist] off BSC- pt. simply stated 'forgot to ring my call light.' Informed CNAs to not leave res. unattended on BSC. Will have chg nurse to notify [physician] to obtain X-rays to R/O [rule out] any Fx's...." 10/12/12 at 9:05 A.M.: "Call out to [physician] spoke...about incident et [and] Res c/o pain LLE. Awaiting return call from MD." 10/12/12 at 10:35 A.M.: "Received [sic] call from MD to send res to ER for Xray of Lt hip, Lt pelvic, et Left Femur..." The resident was transferred to the hospital on 10/12/12 at 11:05 A.M. A Nurses Note, dated 10/12/12 at 4:00 P.M., indicated, "Received call from hospital nurse states res will be admitted D/T [due to] Fx of Lt hip et they will be doing surgery...." On 10/26/12 at 2:30 P.M., during interview with Unit Manager # 1, she indicated staff always pinned the call light to the resident's shirt, and she would ring when she was done using the commode, due to she requested privacy. Unit			

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	Manager # 1 indicated the resident told the staff that she forgot to use the call light and she fell off of the commode. On 10/29/12 at 3:15 P.M., during interview with CNA # 1, she indicated she and another CNA helped Resident A get on the commode on 10/11/12. CNA # 1 indicated the other CNA left to give a shower, and she went down the hall and "came right back." CNA # 1 indicated, "I guess she [Resident A] fell off." CNA # 1 indicated she was new to the facility, and thought it was okay to leave the resident by herself with her call light. 2. On 10/30/12 at 10:45 A.M., the Director of Nursing provided the current facility policy on "Accidents prevention," dated 2006. The policy included: "...Adequate supervision and assistance devices to prevent accidents. The facility identifies residents who may be at risk for accidents and/or falls...Assessments and care plans are used to develop and implement procedures to prevent accidents. This is especially significant when the resident has...cognitive loss, dementia...." This federal tag relates to Complaint IN00117308. 3.1-45(a)(1)			

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